CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/13/2011			
	PROVIDER OR SUPPLIER	 - ND SKILLED NURSING CENTE	<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COI ITTLE LEAGUE BLVD SVILLE, IN47129	DE	
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F0000	Complaints IN IN00090287. Complaint IN0 Substantiated. deficiencies reallegations are F309, and F33 Complaint IN0 Substantiated. deficiencies reallegations are F333, and F44 Unrelated deficiencies reallegations are F333, and F44	Federal/state elated to the excited at F157, F282, 3. 00090287 - Federal/state elated to the excited at F282, F309, 1. ciencies are cited. 5/11, 5/12, and er: 000059 per: 155697	FO	0000			
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DHM211

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING		00 	COMPLETED 05/13/2011		
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TAG	Census bed ty SNF: 10 SNF/NF: 61 Total: 71 Census payor Medicare: 14 Medicaid: 48 Other: 9 Total: 71 Sample: 9 These deficier findings cited 410 IAC 16.2	type: ncies also reflect state in accordance with v completed 5-16-11		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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F0157	•	nediately inform the					
SS=D		vith the resident's physician; fy the resident's legal					
	representative or an interested family member when there is an accident involving the						
		ults in injury and has the					
		ing physician intervention; a					
		in the resident's physical, social status (i.e., a					
	deterioration in he	• •					
		is in either life threatening					
	conditions or clinical complications); a need to						
	_	nificantly (i.e., a need to					
		sting form of treatment due					
		quences, or to commence a nent); or a decision to					
		ge the resident from the					
	facility as specified						
	,	lso promptly notify the					
		own, the resident's legal					
	-	nterested family member					
		ange in room or roommate ecified in §483.15(e)(2); or					
		ent rights under Federal or					
	_	ations as specified in					
	paragraph (b)(1)	of this section.					
	update the addres	ecord and periodically as and phone number of the presentative or interested					
	Based on reco	rd review and	F0	157	The creation and submission		05/27/2011
	interview, the	facility failed to			this plan of correction does n constitute an admission by th	nis	
	ensure follow-up with the physician				provider of any conclusion se	et	
related to treatment plans for		_			forth in the statement of deficiencies, or of any violation	on of	
	resident whose	e lab work indicated			regulation. This provider respectfully requests that the 2567 plan of		
		urine (Resident B).					
The deficient practice aff		practice affected 1 of			correction be considered the		

000059

NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER STRIKET ADDRESS, CITY, STATE, JAPP CODE 517 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 SUMMARY STATEMENT OF DEFICIENCIES TAG 8 residents reviewed related to physician notification in a sample of 9. Findings include: The clinical record for Resident B was reviewed on 5/11/11 at 12:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, urinary retention, and the resident had a Foley urinary catheter. A physician's order, dated 3/6/11, indicated the resident was started on an antibiotic for 10 days related to urinary tract infection. The order also indicated, "Reculture urine 24 hours after last dose." A lab report indicated urine was collected 3/17/11 and urinalysis results were received that same date with the following indicated, "Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten STRIKET ADDRESS, CITY, STATE, JAPP CODE 517 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SUMMARY STATEMENT OF DEFICIENCIES 157 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICIENCIES 17 N. LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 ID SHOWLAGE STATEMENT OF DEFICENCIES 18 ID SHOWLAGE STATEMENT OF ORTH TO A Idea of Calcument of College State of College State of College Blog State of College Stat		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL	
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A physician's order, dated 3/6/11, indicated the resident was started on an antibiotic for 10 days related to urinary tract infection. The order also indicated, "Reculture urine 24 hours after last dose." A lab report indicated urine was collected 3/17/11 and urinalysis results were received that same date with the following indicated, "Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten be accomplished for those residents found to have been affected by the deficient practice: How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including notifying physician and post tests completed Treatment Administration Records were reviewed to ones, and affected by the deficient practice: How will you identify other residents having the potential to be affected by the eame deficient practice and what corrective action will be taken: What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including notifying physician and post tests completed Treatment Administration Records were reviewed to ones, and affected by the deficient practice: How will you identify other residents having the potential to be affected by the same deficient practice: How will you identify other residents having the potential to be affected by the same deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice does not recur Licensed nurses will be put into place or what systemic changes you will make to ensure that the deficient practice.		· ·					rill	
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results were received that same date with the following indicated, "Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including notifying physician and post tests completed Treatment Administration Records were reviewed to		•						
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"Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten including notifying physician and post tests completed Treatment Administration Records were reviewed to onsure all lab orders present.		results were re	eceived that same date				he	
"Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten including notifying physician and post tests completed Treatment Administration Records were reviewed to onsure all lab orders present.		with the follow	wing indicated,			policy for laboratory orders	3,	
follow on separate report." An unsigned, undated handwritten and post tests completed Treatment Administration Records were reviewed to							an	
unsigned, undated handwritten Records were reviewed to		•	••					
oneuro all lab ordore procent		_	_					
i i ciaule di lau viuela vieaciil.		_				ensure all lab orders prese	nt.	
notation on the report indicated, The DNS/designee will log and		notation on the	e report indicated,			-		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155697	A. BUII B. WIN			05/13/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN47129		
						OVE	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
1110		ESC IDENTIFICATION IN CREMITED BY		1110	track lab orders on Lab	DATE	
	"MD aware."				Tracking Log to include dat	e of	
					order, date lab notified, date	l l	
	A lab report fo	or Culture and			drawn, date results receive		
	Sensitivity da	ted 3/19/11 indicated,			and date physician notified	.	
	· ·				How the corrective action(s	•	
) Pseudomonas			will be monitored to ensure		
	aeruginosa > [greater than] 100,000			deficient practice will not re		
	CFU/ml [color	ny forming units/per			A CQI Audit of laboratory to will be utilized weekly x 4	001	
	milliliter]"				monthly x 2 then quarterly		
					thereafter to monitor for		
					compliance.		
	A lab report fo	or Culture and			Compliance Date: 5/27/2011		
	Sensitivity, da	ted, 3/21/11			::		
	indicated, "1)P	Pseudomonas			The facility recognizes that		
		00,000 CFU/ml 2)			residents with laboratory ordenate the potential to be affect		
	_				by this practice.	leu	
		faecalis 50-60,000			A full facility audit was condu	cted	
	CFU/ml 3)Yea	st present, no sens			All medical records identified		
	[sensitivity] w	ill be done			were reviewed to ensure		
	50-60,000. Ha				physician notification was		
					completed. Licensed nurses were educa	tod	
		ndated, unsigned,			on 5/26/2011 on the policy for		
	and lined throu	ugh on this report			laboratory orders including		
	beneath a list of	of antibiotics to			notifying physician with post	test	
	which the orga	anisms were			completed		
	_				The physician was notified of		
	susceptible wa				lab results of resident B on 4 for medication clarification ar	l l	
		0 mg Line place 1 gm			again on 4/6/11 with stat lab		
	IV [intravenou	ıs] q [every 12 hours]			ordered.		
	X 7 days." Initials on page one of the report were dated 4/5/11, and initials on page two of the report				Lab was completed showing		
					potassium level within norma	al	
					limits.		
					•		
	were dated 4/1	/11.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLE		
THE LETTING	or condition	155697	A. BUI B. WIN			05/13/20	
NAME OF B	DOWNER OF GUIDNIES		B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION AN	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	Nurse's Notes,	dated 3/20/11 at				İ	
	2:00 a.m., indi	cated, "Lab report					
	received, NP [1	nurse practitioner]					
	[name] notified	d, instructions					
	received to fax	a labs to office"					
	Documentation	n failed to indicate					
	further contact	with the physician					
	_	tioner for follow-up					
	treatment for the	he resident related to					
	the abnormal l	ab reports.					
		-11-11-1					
		ew on 5/12/11 at 4:45					
	1 ,	n at 5:15 p.m. the					
	-	e Consultant on					
		ted she did not yet					
		r to the question					
		follow-up with the					
		ted to the abnormal					
	labs and was s	•					
		She also indicated the					
	initials on 4/1/						
		Nurse Practitioner had					
	-	t dated 3/21/11,					
		fter the report was					
	•	nysician's office for					
	_	further information					
	was provided.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155697	A. BUILDING	00	05/13/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		I	ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	CLARK	SVILLE, IN47129	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1110	This federal ta		1110		DATE
	Complaint #I				
		1100070073.			
	3.1-5(a)(3)				
	3.1-3(a)(3)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DDIC	00	COMPL	ETED
		155697	B. WING			05/13/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0225 SS=D	have been found of or mistreating residual have had a finding	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State concerning abuse, neglect,					
	mistreatment of re	sidents or misappropriation					
		ind report any knowledge it					
		a court of law against an					
		would indicate unfitness for aide or other facility staff to					
		de registry or licensing					
	authorities.	3 , 3					
	The facility must ensure that all alleged						
	3	g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are rely to the administrator of					
		other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).						
	The facility must h	ave evidence that all					
		are thoroughly investigated,					
	and must prevent the investigation is	further potential abuse while					
	uie iiivesiigalioii is	s in progress.					
		nvestigations must be					
	•	ministrator or his designated					
		d to other officials in State law (including to the					
		certification agency) within 5					
		e incident, and if the alleged					
		appropriate corrective					
	action must be tak		EOO	25	This provider respectfully		05/27/2011
	Based on reco		F02	2.23	This provider respectfully requests additional evident	iary	05/27/2011
	interview, the facility failed to ensure an allegation of abuse was				information be entered into the 2567L and removal of citation		
	investigated for	or 1 of 1 resident			for resident J. The current 2567L information omits		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN	G		05/13/2	011
NAME OF I	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
		ted to allegations of			significant facility information and therefore misrepresen		
	abuse in a san	nple of 9. (Resident J)			the care and assessment		
					administered by the provid	der.	
	 Findings incl	ıde·			Resident J is diagnosed w		
					personality disorder and c		
	During inter-	iovy on 5/12/11 of 1.25			planned for chronic compl about staff, peers and care		
	1	iew on 5/12/11 at 1:35			verbal and physical aggres		
	1 *	t J indicated about a			toward staff and peers; an		
	month ago he	was assaulted by			making false statements a		
	LPN #3. Res	ident J indicated the			accusations toward staff.P		
	nurse came in	to his room and said			surveyor comment on pag of 43 " the facility failed to	e 6	
		take his vital signs,			ensure an allegation of abo	use	
		- she proceeded			was investigated for 1 or 1		
		•			residents reviewed related	to	
	1 -	the struggle took			allegations of abuse in a		
	place." When	asked if he pushed			sample of 9"This implies to the facility had an allegation		
	her away, the	resident indicated he			that the resident claimed)II	
	had when she	tried to grab his arm,			related to abuse and that r	10	
	so she tried to	put the blood			investigation was complet		
		on his leg, and he			Resident J did have an epi		
	kicked at her.				of refusal of care on 4-5-11 resident concern for behave	_	
					grew when resident became		
		nad a stroke in the past			physically aggressive with	l	
		ave use of his left arm			nurse for no apparent reas	on.	
	and left leg. I	He indicated the nurse			Further investigation was completed by Executive		
	said she woul	d put the blood			Director, due to resident J	had	
	pressure cuff	on his left leg. He			wanted to exercise his righ		
	_	could not straighten			refuse all his medications		
		mpletely since his			care and he wanted the nu		
		•			discharged from the facilit Executive Director wanted	-	
		esident indicated the			reassure him of his rights		
		r fist and hit his left			also provide further		
	knee cap hard	to make his leg go			understanding that there a	re	
	<u> </u>						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155697	B. WIN			05/13/2011	
			<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	risks to his own health and	DATE	
out straight. The resident indicated				wellness by refusals of car			
	he had talked t	to the Administrator			and furthermore, nursing n	l l	
	and Director o	f Nursing about the			also provide that education	ı .	
	situation.				The facility contends that a		
	2				investigation was complete	ed to	
	D : 41	. , .			ensure that there was no		
	During the san	<i>'</i>			allegation of abuse. Althou no allegation from resident	- 1	
	Resident J ind	licated on the day			made, the nurse was educa		
	before the inci	dent about the vital			on abuse policy for the		
	signs, he was i	making his way			prevention of potential of		
	_	wheel chair down the			abuse. Nurse was explaine	l l	
	_				that per resident request, n	urse	
		e nurse's station. He			would not be assigned to resident. It is the practice of	ا ،	
	indicated with	one arm and leg			this facility to ensure an	"	
	functioning, he	e could not move			allegation of abuse is		
	_	resident indicated			investigated. The policy wa	s	
	1	nergency Medical			followed as evidenced base	ed	
	,	- ·			by which a concern was		
	· ·	vere coming down the			brought to the attention of		
	hall with a resi	ident on a gurney,			ED when resident J made a allegation of abuse on 4/25		
	and he was try	ring to get out of their			to ISDH surveyor that resid	l l	
	wav. He indic	eated the situation was			s right to refuse was violate	l l	
	-	ncy run, and he was			on 4/5/11. Once the allegati	l l	
					was made the ED immediat	ely	
		ckly as he could. The			responded and an	The	
		ated LPN #3 hollered			investigation was initiated. nurse was suspended upor		
	at him from be	ehind the nurse's			further investigation. Resid		
	station to get of	out of the way,			and former roommate, as w	l l	
	_	m behind the counter,			as staff was interviewed. S		
		shoved his wheel			member and former roomm		
					had no care concerns from		
	_	et him out of the			nurse. During investigation resident spoke to ISDH	·	
	way. Resident	t J did not indicate he			surveyor and stated nurse	had	
	had reported th	his incident.			forced him to take vitals an	l l	
	1						

000059

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUI	BUILDING 00 COMPLETED 05/13/2011		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	1 3 3 3 3 3 3
NAME OF F	PROVIDER OR SUPPLIER			1	TTLE LEAGUE BLVD	
		ND SKILLED NURSING CENT	ER	1	SVILLE, IN47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	-	IAG	assaulted him by violating	
					right to refuse. Resident m	• • • • • • • • • • • • • • • • • • •
		4:45 p.m. during			with Ombudsman and clair	I
	interview abou	at the Resident J's			that the nurse took his block	od
	report of assau	ılt, the Administrator			pressure on the right side.	I
	_	of a Fax Incident			Then stated to ED that she her right hand and slamme	
		m, dated 4/25/11,			his arm on the bed and trie	
	1 '				put cuff on arm then reside	
		der and the facility's			tried to pin her hand down	
		tion, Reporting, and			Then claimed that she took	
	Investigation I	Policy and Procedure.			fist and pinned his leg dow and tried to take Bp on left	I
	The Administr	rator indicated she			His story became more and	<u> </u>
	could allow or	nly the Fax Incident			more elaborate as he	
		m to be reviewed,			developed the allegation w	• • • • • • • • • • • • • • • • • • •
		inder of the file			interviewed each time with	
					each interviewer. Resident a way of word manipulation	
	related to the i	ncident was			his best interest. Resident	• • • • • • • • • • • • • • • • • • •
	confidential.				care planned for tendency	I
					provoking peers by using	
	Review of the	Fax Incident			obscene gestures and calli	- 1
	Reporting For	m indicated the			names. Resident is diagno- with personality disorder a	l l
		ved was Resident J,			is being treated and follow	• • • • • • • • • • • • • • • • • • •
		vas LPN #3. The			by psychiatrist. The facility	• • • • • • • • • • • • • • • • • • •
					contends that an investiga	tion
	1	otion of Incident"			was completed and the	
	ĺ	4/25/11 Resident			procedures for abuse police was followed for resident J	· .
	allegation to Is	SDH [Indiana State			respectfully requests the	, und
	Department of	Health] surveyor			removal of the citation. The	e
	_	right to refuse was			facility did in fact investiga	· ·
		5/11. Allegation was			suspend employee, and rewhen a true concern was	port
		sident and forced to			identified. However, in	
					response to the alleged	
	-	signs] when resident			deficient practice the follow	_
	declined. Res	ident has a history of			corrective action has been	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155697 05/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE implemented.

Nurse was false accusations and is care suspended pending further planned. Resident did not report investigation. above allegation to facility until Multiple employees and residents were questioned and 4/6/11." no trends of concerns for care were found. During the Exit Conference on ED will continue to use facility form for investigation to 5/12/11 at 5:45 p.m., the include larger sample of Administrator indicated she would questionnaire of staff and residents. allow review of the file of the Ombudsman contacted for incident with Resident J but could support to resident. allow no copies of certain Counseling and 1:1 visits offered to resident as confidential documentation to be suggested by Ombudsman; made. however, resident continues to deny these services. This information was reviewed by A file folder labeled with the name the surveyors during annual of Resident J and the date of 4/5/11 survey and no deficiencies were cited. was provided by the Administrator F225 - Addendum for review on 5/13/11 at 12:45 p.m. How other residents having The folder included, but was not the potential to be affected by the same deficient practice will limited to, documentation on a form be identified and what titled, "Resident Event corrective action(s) will be Investigation Questionnaire." The taken? Questionnaire indicated a date of Due to the nature of the 4/7/11 related to an incident on citation, all residents have the 4/5/11. The form indicated, potential to be effected by the "Nature of Event: Res. Abuse: same alleged deficient Allegation?" The folder also practice. Nurse was suspended included a statement written and pending further investigation. signed by LPN #3 indicating the Multiple employees and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	Ì	LDING	00	(X3) DATE S COMPLI 05/13/20	ETED
NAME OF PROVIDER OR SUPPLI	ER AND SKILLED NURSING CENTER	₹	517 N LI	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
following: of 4/5/11, LPN times to adm medications, refused; me the nurse the was enroute needed the retaken before put her left hed rail to go and the residence cursing; the nurse's left he hand; the nurse munurse only a signs on the The folder a documentati	on the morning of #3 attempted three inister the resident's and the resident dical records informed resident's physician to the facility and esident's vital signs he arrived; the nurse and on the resident's et the blood pressure, ent began yelling and resident scratched the and with his right rse tried to leave the sident hit and kicked at altiple times; and the tempted to obtain vital resident's right arm.			CROSS-REFERENCED TO THE APPROPRIA	d s for ut ic use on to e tion n g (s) e not e put udit	
Resident Rig for with] Re- approach cal space, attem	buse Prevention, ghts, Approach [symbol sident, Ensure to mly, provide personal pt with different staff eviewed behavior care			each investigation to ensuce compliance with investigation and reporting procedures. By what date the systemic changes will be completed. June 6, 2011	ire tion	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697				LDING	NSTRUCTION 00		(X3) DATE COMPI 05/13/2	LETED
N. 25	DROLUBER OR STORE	<u> </u>	D. WIN		DDRESS, CITY, STAT	TE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K		517 N LI	ITTLE LEAGUE	BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	ER	CLARKS	SVILLE, IN47129	9		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCEI	D TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
		,						
	During intervi	iew with the						
	_	on 5/13/11 at 2:45						
	p.m., the Adm	ninistrator indicated						
	*	n 4/5/11 was not						
	investigated a	s an allegation of						
	_	orted to the Indiana						
	1	nent of Health,						
	1	esident was not						
	alleging assau	lt. The Administrator						
		concern about the						
	nurse had con	ne up during a						
		between her and the						
	resident, and v	when she had asked						
	the resident if	the nurse had put her						
	hands on him,	he said no. The						
	Administrator	indicated the resident						
	is manipulativ	ve and now is using						
	the idea about	the nurse putting her						
	hands on him,	since he wants the						
	nurse fired. T	The Administrator						
	indicated she	did not interview						
	anyone except	t the resident's former						
	roommate abo	out the incident on						
	4/5/11, and sh	e did not write						
	documentation	n related to the						
	interview. Th	e Administrator						
	indicated the i	resident's behaviors						
	and managem	ent of the resident's						
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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPLE 05/13/20	ETED
PROVIDER OR SUPPLIER		B. WIN	STREET A		13,10,20	
REHABILITATION AI	ND SKILLED NURSING CENTER					
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	1 ,					
_	· ·					
The Administr	ator indicated the					
resident report	ed the incident as					
assault to the s	tate surveyors on					
_	•					
recertification	survey.					
Danin a tha agu						
_	· ·					
_	•					
	-					
	•					
•	~					
_						
•						
-						
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_						
	-					
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	SUMMARY S (EACH DEFICIENT REGULATORY OR Dehaviors are of at Interdisciplic The Administrator assault to the second department of a the Indiana State Indiana India	OF CORRECTION IDENTIFICATION NUMBER: 155697 PROVIDER OR SUPPLIER	REHABILITATION AND SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) behaviors are discussed frequently at Interdisciplinary Team meetings. The Administrator indicated the resident reported the incident as assault to the state surveyors on 4/25/11 during the facility's recent recertification survey. During the same interview, he Administrator indicated the allegation of abuse was reported to the Indiana State Department of Health when state surveyors reported the resident's allegation of assault to her on 4/25/11. The Administrator indicated her notes about the allegation of assault from the surveyors were the "chicken scratch" documentation in the file. The Administrator looked at the documentation and indicated the surveyors told her: the resident reported assault; the nurse took her right hand and slammed on the bed; the nurse took her fist, pinned his leg down, and tried to take his blood pressure on his left leg; and the nurse put her hands on him	REHABILITATION AND SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (BEACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) behaviors are discussed frequently at Interdisciplinary Team meetings. The Administrator indicated the resident reported the incident as assault to the state surveyors on 4/25/11 during the facility's recent recertification survey. During the same interview, he Administrator indicated the allegation of abuse was reported to the Indiana State Department of Health when state surveyors reported the resident's allegation of assault to her on 4/25/11. The Administrator indicated her notes about the allegation of assault from the surveyors were the "chicken scratch" documentation in the file. The Administrator looked at the documentation and indicated the surveyors told her: the resident reported assault; the nurse took her right hand and slammed on the bed; the nurse took her fist, pinned his leg down, and tried to take his blood pressure on his left leg; and the nurse put her hands on him	DENTIFICATION NUMBER: 155697 RECORDER OF SUPPLIER REHABILITATION AND SKILLED NURSING CENTER REHABILITATION AND SKILLED NURSING CENTER REHABILITATION AND SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) behaviors are discussed frequently at Interdisciplinary Team meetings. The Administrator indicated the resident reported the incident as assault to the state surveyors on 4/25/11 during the facility's recent recertification survey. During the same interview, he Administrator indicated the allegation of abuse was reported to the Indiana State Department of Health when state surveyors reported the resident's allegation of assault to her on 4/25/11. The Administrator indicated her notes about the allegation of assault from the surveyors were the "chicken scratch" documentation in the file. The Administrator looked at the documentation and indicated the surveyors told her; the resident reported assault; the nurse took her right hand and slammed on the bed; the nurse took her fist, pinned his leg down, and tried to take his blood pressure on his left leg; and the nurse put her hands on him	DENTIFICATION NUMBER: 155697 ROYLOR OF SUPPLIER REHABILITATION AND SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, INA7129 PREFIX TAG TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, INA7129 TAG TO STATE LEAGUE BLVD CLARKSVILLE, INA7129 TAG TAG TAG TAG TAG TAG TAG TA

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUI	LDING	00	COMPL		
		155697	B. WIN	IG		05/13/2	011
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			_	1	ITTLE LEAGUE BLVD		
CLARK I	REHABILITATION A	ND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		f why she had to get					5.112
	the blood pres	•					
	_	indicated she may					
		tes in the resident's					
		to the allegation of					
		ed by the surveyors.					
	An Employee	Communication					
	Form in the fi	le folder indicated					
	LPN #3 was s	uspended 4/25/11 and					
		ork 4/25/11. The form					
	indicated, "En	nployer Statement:					
		was alleged that EE					
	[meaning unco	ertain] assaulted					
	resident per re	esident's claim," and					
	"Summary of	Discussion with					
	Employee: Pe	er Abuse Prohibition,					
	Reporting & I	nvestigation, it is the					
		to remove staff and					
	remain suspen						
	1 *	is completed. Upon					
	investigation,	• •					
	1	EE story remain the					
	_	ise was found. EE					
	may return aft	er reading resident					
	1	npletion of test."					
		•					
	During the sar	me interview, the					
	_	indicated no further					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAIN	OF CORRECTION	155697	A. BUII		00		05/13/2	
		1.55507	B. WIN		DDRESS, CITY, STATE	ZID CODE	00,10/2	
NAME OF P	PROVIDER OR SUPPLIEF	R			ITTLE LEAGUE B			
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	ĒR	1	SVILLE, IN47129			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED DEFICIE	TO THE APPROPRIAT	E	COMPLETION DATE
IAG		nto the allegation		IAG				DAIL
	_	er surveyors reported						
		nurse had assaulted						
	the resident.	nuise nau assauneu						
	the resident.							
	Desident I's re	ecord was reviewed on						
		5 p.m. The record						
		resident's diagnoses						
	· ·	were not limited to,						
		mplicated dementia,						
		ire, mood disorder,						
	and hemiplegi	a.						
	*	D 37.						
	•	ry Progress Notes,						
		at 5:00 p.m. and						
		Administrator,						
		is writer spoke with						
	Ombudsman [name of local						
	Ombudsman]	r/t [related to]						
	meeting with	resident. Resident						
	alleged that nu	urse forced him to get						
	vitals X 2 onc	e in his right arm and						
	then on his rig	tht leg/ankle which						
	_	from his allegation						
		interviews. Resident						
	•	of making false						
	_	ward staff" The						
		n failed to indicate						
		gation into the						
	13101101 1111 0501							
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155697 05/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE allegation of assault reported by the state surveyors on 4/25/11. 3.1-28(d)F0226 The facility must develop and implement written policies and procedures that prohibit SS=D mistreatment, neglect, and abuse of residents and misappropriation of resident property. This provider respectfully F0226 05/27/2011 Based on record review and requests additional evidentiary interview, the facility failed to information be entered into the 2567L and removal of citation for ensure its policy was followed resident J. The current 2567L related to investigation of information omits significant allegations of abuse for 1 of 1 facility information and therefore misrepresents the care and resident reviewed related to assessment administered by the allegations of abuse in a sample of provider. Executive Director reported to ISDH once facility 9. (Resident J) became aware of the allegation. The information obtained prior to the surveyor did not meet the Findings include: reportable guidelines. Reportable policy was followed, once the The facility's policy and procedure allegation of abuse was brought to the facility's attention. Resident for Abuse Prohibition, Reporting, J is diagnosed with personality and Investigation was provided by disorder and care planned for chronic complaints about staff, the Administrator on 5/12/11 at peers and care; verbal and 4:45 p.m. In the section of the physical aggression toward staff and peers; and making false policy titled "Resident Abuse - Staff statements and accusations member, volunteer, or visitor" toward staff.Per surveyor comment on page 6 of 43 " the indicated, "...9. Residents will be facility failed to ensure an questioned (if alert and competent) allegation of abuse was about the nature of the incident, and investigated for 1 or 1 residents reviewed related to allegations of

Facility ID:

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MI A. BUII B. WIN		00	(X3) DATE S COMPL 05/13/2	ETED
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N LI	DDRESS, CITY, STATE, ZIP CODE TTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	writing. 10. A be done to ass have not been incident or ina and the results. The investigat Facts and observations in the investigation in t	rs; Facts and rom others who rtinent information; ervations by the individual when the			abuse in a sample of 9"This implies that the facility had a allegation that the resident claimed related to abuse and no investigation was comple Resident J did have an episorefusal of care on 4-5-11. The resident concern for behavior grew when resident became physically aggressive with noterino of the president J aggressive with noterino of the president J had wanted to exemply a significant of the provided to the provided to the provided to the provided to the provided further understanding that the provided that education. The facility contends that an investigation was completed ensure that there was not allegation of abuse. Although allegation from resident was made, the nurse was educated abuse policy for the prevention potential of abuse. Nurse was explained that per resident request, nurse would not be assigned to resident. It is the practice of this facility to ensure that the policy was followed as evidenced based which a concern was brough the attention of the ED when	that ted. ode of e r urse ner by ercise e d him ere nd and so to n no ed on of s	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUI	LDING	00	COMPI 05/13/2	
		100097	B. WIN			03/13/2	.011
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP CODE		
CLARK	REHABII ITATI∩N ∆	ND SKILLED NURSING CENTER	₹	1	LITTLE LEAGUE BLVD SVILLE, IN47129		
			` 				(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	so she tried to	put the blood			resident J made an allegati	on of	
		on his leg, and he			abuse on 4/25/11 to ISDH		
	kicked at her.				surveyor that resident's right refuse was violated on 4/5/		
					Once the allegation was ma		
		ad a stroke in the past			the ED immediately respon		
		ive use of his left arm			and an investigation was in The nurse was suspended		
	_	He indicated the nurse			further investigation. Reside		
	said she would	d put the blood			and former roommate, as w		
	pressure cuff	on his left leg. He			staff was interviewed. Staff	ato	
	indicated he c	ould not straighten			member and former roomm had no care concerns from		
		mpletely since his			During investigation, reside		
	1	esident indicated the			spoke to ISDH surveyor and		
		fist and hit his left			stated nurse had forced hin take vitals and assaulted hi		
					violating his right to refuse.	п Бу	
	_	to make his leg go			Resident met with Ombuds		
	1	The resident indicated			and claimed that the nurse		
	he had talked	to the Administrator			his blood pressure on the ri side. Then stated to ED tha		
	and Director of	of Nursing about the			took her right hand and slar	nmed	
	situation.				his arm on the bed and tried		
					put cuff on arm then resider to pin her hand down. Then		
	The resident a	lso indicated on the			claimed that she took her fi		
		s incident, he was			pinned his leg down and tri		
	1 -				take Bp on left leg. His story became more and more	/	
	1	ay slowly in his wheel			elaborate as he developed	the	
		e 20-hall near the			allegation when interviewed		
		. He indicated with			time with each interviewer.		
	one arm and le	eg functioning, he			Resident has a way of word manipulation to his best into		
	could not mov	ve very fast. The			Resident is care planned fo		
	resident indica	ated the EMTs			tendency for provoking pee	rs by	
	(Emergency N	Medical Technicians)			using obscene gestures and calling names. Resident is	d	
	1 '	down the hall with a			diagnosed with personality		
	1	gurney, and he was			disorder and is being treate		
	resident on a §	zumey, and he was			followed by psychiatrist. Th	e	
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NAME OF I	PROVIDER OR SUPPLIER		B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/10/2	
		ND SKILLED NURSING CENTER	₹	1	ITTLE LEAGUE BLVD SVILLE, IN47129		
	trying to get of indicated the semergency, are quickly as her indicated LPN from behind the get out of the behind the conshoved his whole indicate her incident. On 5/12/11 at interview related Administrator Fax Incident Fax I	ND SKILLED NURSING CENTER STATEMENT OF DEFICIENCIES (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ut of their way. He situation was not an ad he was moving as could. The resident [#3 hollered at him he nurse's station to way, jumped up from anter, and came and heel chair hard to get way. Resident J did had reported this 4:45 p.m., during the ted to the assault, the provided copy of a Reporting Form, dated a file folder and the he Prohibition, de Investigation Policy he. During interview at	2	517 N L	ITTLE LEAGUE BLVD	d and blicy and moval d in a true vever, ang dents and of id. ity ude ire of dent vices. and by were	(X5) COMPLETION DATE
	confidential.				and what corrective action(s) will be taken?		
	Review of the	Fax Incident			· Due to the nature of	of the	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155697	B. WIN			05/13/20	[]
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	DEHARII ITATION AN	ND SKILLED NURSING CENTER		1	ITTLE LEAGUE BLVD SVILLE, IN47129		
			,	<u> </u>	SVILLE, 1114/ 129	,	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Reporting Form	m indicated the			citation, all residents have	the	
	1 0	ved was Resident J,			potential to be effected by	the	
	and the staff w	ras LPN #3. The			same alleged deficient practice.		
		tion of Incident"			Nurse was suspend	led	
	_	4/25/11 Resident			pending further investigation	on.	
	· ·	SDH [Indiana State			· Multiple employees		
		`Health] surveyor			residents were interviewed and no trends of concerns		
	_	right to refuse was			care were found.		
		5/11. Allegation was					
		ident and forced to			What magazines will be se-		
		signs] when resident			What measures will be point oplace or what system		
	-	ident has a history of			changes will be made to	•	
	false accusatio	•			ensure that the deficient		
					practice does not recur?		
	*	dent did not report			ED will continue to u		
		on to facility until			facility form for investigation include larger sample of	on to	
	4/6/11."				questionnaire of staff and		
		. ~ .			residents.		
		it Conference on			· CQI Audit tool will b		
	5/12/11 at 5:45	•			utilized for each investigat		
	Administrator	indicated she would			to ensure compliance with investigation and reporting		
	allow review o	of the file of the			procedures.	'	
	incident with F	Resident J but could					
	allow no copie	es of certain			11. 0		
	_	ocumentation to be			How the corrective action will be monitored to ensu		
	made.				the deficient practice will	I	
					not recur, i.e what quality		
	A file folder la	beled with the name			assurance program will b		
		and the date of 4/5/11			put into place?	. 41:4	
		for review on 5/13/11			 ED/Designee will au using CQI Tool monthly for 		
	mas provided i				using Our 1001 monthly 10	'	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID: DI	HM211	Facility I	D: 000059 If continuation sl	heet Page	e 22 of 71

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2011
	PROVIDER OR SUPPLIER REHABILITATION AI	I ND SKILLED NURSING CENTER	p. why	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	at 12:45 p.m. The but was not lind documentation "Resident Ever Questionnaire, as confidential copied. The Questionnaire and incident on indicated, "Na Abuse: Allega The section of "Interview with indicate specific possible allega documented the history related and mental hear resident's fear and his right to documentation instruction profin regard to approximate the properties of the profit of the p	The folder included, nited to, a on a form titled, nt Investigation "which was marked and not to be uestionnaire e of 4/7/11 related to 4/5/11. The form ture of Event: Res. ation?" the form for h Resident" failed to ics of the resident's ation of abuse, but he resident's family to abuse, alcoholism, alth issues, the of being sent away, orefuse care. The also included vided to the resident propriate expression		TAG	each investigation to ensucompliance with investigation and reporting procedures. By what date the system changes will be completed June 6, 2011	DATE ure tion .
	The folder also statement write	ollowing policy. o included a ten and signed by the following:				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S	
		155697	A. BUII B. WIN	LDING IG		05/13/2	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NURSING CENTER	,		ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES	<u>, </u>	ID			(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE
	`	g of 4/5/11, LPN #3					
	_	e times to administer					
		nedications, and the					
		ed; medical records					
	informed the n	nurse the resident's					
	physician was	enroute to the facility					
	and needed the	e resident's vital signs					
	taken before h	e arrived; the nurse					
	put her left har	nd on the resident's					
	bed rail to get	the blood pressure,					
	and the resider	nt began yelling and					
	cursing; the re	sident scratched the					
	nurse's left har	nd with his right					
	hand; the nurse	e tried to leave the					
	room, the resid	dent hit and kicked at					
	the nurse mult	iple times; and the					
	nurse only atte	empted to obtain vital					
	signs on the re	sident's right arm.					
	The folder also	o included					
	documentation	n of inservice					
	provided to LF	PN #3 on 4/7/11					
	related to "Ab	use Prevention,					
	Resident Right	ts, Approach [symbol					
	for with] Resid	dent, Ensure to					
	approach calm	ly, provide personal					
	space, attempt	with different staff					
	member. Revi	iewed behavior care					
	plan."						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/13/2	LETED
	PROVIDER OR SUPPLIEF	II R ND SKILLED NURSING CENTER	1	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	During intervitation Administrator p.m., the Administrator p.m., the Administrator p.m., the Administrator or investigated as abuse and reposit abuse and reposit alleging assault indicated the conversation because the con	ew with the on 5/13/11 at 2:45 inistrator indicated in 4/5/11 was not is an allegation of orted to the Indiana ient of Health, esident was not lt. The Administrator concern about the		TAG	DEFICIENCY)		DATE
	the resident if hands on him, Administrator is manipulative the idea about hands on him, nurse fired. To indicated she anyone except roommate about 4/5/11, and she documentation interview. The indicated the reand managem	the nurse had put her he said no. The indicated the resident re and now is using the nurse putting her since he wants the he Administrator did not interview the resident's former out the incident on he did not write he related to the he Administrator resident's behaviors ent of the resident's discussed frequently					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			A. BUI	LDING	00	COMPLETED
		155697	B. WIN	G		05/13/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
CLARKE	PEHARII ITATION AI	ND SKILLED NURSING CENTER	2		LITTLE LEAGUE BLVD SVILLE, IN47129	
			`	ID	I	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	at Interdiscipli	nary Team meetings.				
	The Administr	rator indicated the				
	resident report	ted the incident as				
	assault to the s	state surveyors on				
	4/25/11 during	the facility's recent				
	recertification	survey.				
	During the san	ŕ				
	Administrator	indicated the				
	allegation of a	buse was reported to				
	the Indiana Sta	ate Department of				
	Health when s	tate surveyors				
	reported the re	esident's allegation of				
	assault to her of	on 4/25/11. The				
	Administrator	indicated her notes				
	about the alleg	gation of assault from				
	the surveyors	were the "chicken				
	scratch" docur	mentation in the file				
	folder. The Ad	lministrator looked at				
	the documenta	ation and indicated				
	the surveyors t	told her: the resident				
	reported assau	lt; the nurse took her				
	•	slammed on the bed;				
	_	her fist, pinned his				
		tried to take his				
	_	e on his left leg; and				
	_	ner hands on him				
	_	ssion, and gave no				
	_	why she had to get				
	1	<u> </u>				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				INSTRUCTION 00	(X3) DATE S COMPL		
		155697	A. BUIL B. WING			05/13/2	
NAME OF E	PROVIDER OR SUPPLIER		D. WIII		ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the blood press	sure. The					
	Administrator	indicated she may					
	have made not	es in the resident's					
	record related	to the allegation of					
ı	assault reporte	d by the surveyors.					
	An Employee	Communication					
	Form in the fil	e folder indicated					
	LPN #3 was su	uspended 4/25/11 and					
	returned to work 4/25/11. The form						
	indicated, "Em	ployer Statement:					
	On 4/25/11 it v	was alleged that EE					
	[meaning unce	ertain] assaulted					
	resident per re	sident's claim," and					
	"Summary of l	Discussion with					
	Employee: Pe	er Abuse Prohibition,					
	Reporting & In	nvestigation, it is the					
	facility policy	to remove staff and					
	remain suspen	ded until					
	investigation is	s completed. Upon					
	investigation,	resident story					
	changed and E	E story remain the					
	same. No abu	se was found. EE					
	may return afto	er reading resident					
	rights and com	pletion of test." The					
	document was	signed by LPN #3					
	and the DON	on 4/25/11 and by the					
	Administrator	on 4/27/11.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697			LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/13/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
		ND SKILLED NURSING CENTER	•	1	ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES	` 	ID	OVILLE, IIV+7 120		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		rator indicated no					
		gation into the					
	_	s made after surveyors					
	_	r that the nurse had					
	assaulted the i	esident.					
	 Desident I's re	ecord was reviewed on					
		5 p.m. The record					
		•					
	indicated the resident's diagnoses included, but were not limited to,						
	1	mplicated dementia,					
		ire, mood disorder,					
	and hemiplegi						
	Interdisciplina	ary Progress Notes,					
	dated 4/6/11 a	nd signed by the					
	Social Worker	, indicated the					
	resident was e	xperiencing					
	worsening bel	naviors, verbal and					
	physical aggre	ession toward the					
	1	sal of medications					
	and blood sug	ar checks.					
	_	ary Progress Notes,					
		at 5:00 p.m. and					
	, ,	Administrator,					
		is writer spoke with					
	Ombudsman [
	Ombudsman	r/t [related to]					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE					
ANDILAN	or correction	155697	A. BUILDING	j.		05/13/20	
			B. WING	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				TTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER	CL	ARKS	SVILLE, IN47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAC	- 1	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		resident. Resident					
	alleged that nu	rse forced him to get					
	vitals X 2 once in his right arm and						
	then on his rig	ht leg/ankle which					
	was different f	from his allegation					
	from previous	interviews. Resident					
	has a history o	f making false					
	accusations to	ward staff" The					
	documentation	failed to indicate					
	further investigation into the						
	allegation of a	ssault reported by the					
	state surveyors	s on 4/25/11.					
	3.1-28(a)						
E0282	The services provi	ded or arranged by the					
SS=D	facility must be pro	ovided by qualified persons					
		n each resident's written					
		rd review and	F0282	l	F 282 483.20(k)(ii) Services I	by	05/27/2011
					Qualified Persons/Per Care F	Plan	
		-			ensure that ordered laboratory order	ers	
					are obtained and medications are administered as ordered by the		
	_	1 2			physician.		
					accomplished for those residents	,	
	_	,			found to have been affected by the deficient practice:	ne	
					The physician of resident B was no	otified	
					clarification. New orders were rece		
	-				The physician of resident B was no of BMP on 3/9/2011, new orders w		
	1051401165 10 110				received. Labs were completed sta		
F0282 SS=D	facility must be pro- in accordance with plan of care. Based on recon- interview, the ensure lab wor- ordered by the residents revie work in a samp B)The facility medications w	rd review and facility failed to k was obtained as physician for 1 of 8 wed related to lab ple of 9. (Resident also failed to ensure ere administered as physician for 2 of 8	F0282		Qualified Persons/Per Care F It is the practice of this provider to ensure that ordered laboratory order are obtained and medications are administered as ordered by the physician. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The physician of resident B was not of potassium on 4/6/2011 for clarification. New orders were rece The physician of resident B was not BMP on 3/9/2011, new orders were	Plan ers betified ived. otified ere	05/27/201

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	COMPLETED	
		155697	B. WIN			05/13/20)11	
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF	PROVIDER OR SUPPLIE	R		1	ITTLE LEAGUE BLVD			
CLARK I	REHABILITATION A	ND SKILLED NURSING CENTER	₹	1	SVILLE, IN47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL				TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	medication ad	lministration in a			potassium levels within normal lev Licensed nurses were in-serviced			
	sample of 9.	(Residents B and I)			5/26/2011 regarding policy on labs			
	1	,			include completion as ordered by physician and post tests were			
	Findings inclu	ida:			completed			
	Tilldings men	ide.			Resident I's physician was notified	lof		
					medications on 4/26/2011 and 4/27/2011 with new orders receive	ed.		
		al record for Resident			The re-admitted nurse was educate			
	B was review	ed on 5/11/11 at 12:45			regarding re-admitting procedures ensure discharging medications has			
	p.m. The reco	ord indicated the			been ordered.			
	1 *	idmitted to the facility			How will you identify other resident having the potential to be affected to be affected.			
	on 1/21/11.	difficulty to the facility			the same deficient practice and v			
	011 1/21/11.				corrective action will be taken:			
					The facility recognizes that resider with lab orders and those resident			
	A physician's	order, dated 1/24/11,			admitted /re-admitted to the facility			
	indicated, "D/	C [discontinue] Dx			the potential to be affected by this practice.			
	[diagnosis] De	ehydration Add Dx -			A full facility audit was conducted			
	1 2 3	[low potassium],			All medical records identified were reviewed to ensure physician	•		
					notification was completed.			
	nyponatremei	a [low sodium]"			Resident admitted/re-admitted we reviewed to ensure discharge orde			
					were transcribed as verified by			
	Physician's ad	lmission orders,			attending physician.			
	signed by the	physician on 1/23/11,			Licensed nurses were in-serviced 5/26/2011 regarding policy on labs	-		
	1 '	were not limited to,			include completion as ordered by			
	Potassium 40				physician and post tests were completed.			
		•			Licensed nurses were in-serviced	on		
	1 - 1	ents] PO [by mouth]			5/26/2011 regarding admission/re-admission policy to			
	TID [three tin	nes daily]			include verification and transcription	on of		
	(supplement).	"			orders with post tests completed.	laco		
					What measures will be put into p or what systemic changes you w			
	Nurse's Notes	for 3/4/11 at 6:15			make to ensure that the deficient			
					practice does not recur: Licensed nurses were educated o	_n		
	1 ~	l, "Labs reported to			5/26/2011 on the policy for laborat			
	1 ^	ium being @ critical			orders, including completion as or	dered		
	level 6.9, orde	ers received to hold			with post tests completed. Treatment Administration Records	were		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WING			05/13/2	011
		<u> </u>	P. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ITTLE LEAGUE BLVD		
	REHABILITATION A	ND SKILLED NURSING CENTER	_		SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY			(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL			ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	reviewed to ensure all lab orders		DATE
	potassium, start IV [intravenous]				present.		
	NS [normal sa	aline] bolus"			The DNS/designee will log and tra		
					orders on Lab Tracking Log to include date of order, date lab notified, date		
	A. The Medic	cation Administration			drawn, date results received and d	late	
		(a) for March 2011			physician notified. Licensed nurses were also educat	ed on	
	`	resident received no			5/26/2011 regarding admission pol		
					and procedure with post tests completed.		
	1 * *	plements after 3/4/11			The DNS/designee will complete	<i>.</i> .	
	through 3/31/	11.			admission audit first business day admission to include review of	after	
					discharging and admission orders	for	
	Documentation in the physician's				medications. How the corrective action(s) will	ho	
		of the record lacked			monitored to ensure the deficient		
		physician order to			practice will not recur:	20	
					A CQI Audit of laboratory tool will be utilized weekly x 4 monthly x 2 then		
	resume potass	ium supplements.			quarterly thereafter to monitor for		
					compliance. DNS/designee will monitor audits,	to	
	The MAR for	April 2011 indicated		ensure completion of audits.			
	the resident re	eceived potassium			The DNS/designee will complete admission audit first business day	after	
	chloride, 40 m	nEq, by mouth three			admission to include review of discharging and admission orders	for	
	times daily on	4/1, 4/2, and 4/5/11.			medications.		
	1	icated the resident			Data collected will be submitted to CQI Committee for review and follow		
		nedication two times			as needed. An action plan will be	·	
	daily on 4/4 a				developed as needed for issues identified by the CQI process.		
		III T/ U/ 11.			Compliance Date: 5/27/2011		
		1 1 1 1 4 / 7 / 4 4			identifying all laboratory orders.□		
		order, dated 4/5/11,					
	indicated, "KO	Cl [potassium					
	chloride] 10 n	nEq, i [one] PO [by					
	mouth] QD [e	2 2 2 2					
	', ', ',	, , , , , , , , , , , , , , , , , , ,					
	Nurse's Notes	for 4/6/11 at 9:55					
	a.m. indicated	, "Call to ARNP					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē.	(X5) COMPLETION DATE
	[Advanced Re Practitioner] to order"	gistered Nurse o clarify KCl					
	indicated, "D/40 mEq TID [order, dated 4/6/11, C [discontinue] KCl three times daily], 10 mEq PO daily as 5/11.					
	at 6:30 p.m. in orders for the Physician order 9:30 p.m. indiffuids should to infiltration, and "Repeat B profile] q [every street or the profile] q [every st	s orders, dated 3/4/11 adicated specific intravenous fluids. ers, dated 3/4/11 at cated intravenous be discontinued due oral fluids pushed, aMP [basic metabolic ry] a.m. [morning] old potassium."					
	Documentation section of the indication of co						
	p.m., the Med indicated she l	ew on 5/11/11 at 3:50 ical Records Director nad contacted the lab, had been done on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAIN	OF CORRECTION	155697	- 1	LDING	00	05/13/2	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF P	PROVIDER OR SUPPLIER			1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	?	1	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	3/5, 3/6, 3/7, a		-	IAG			DATE
	3/3, 3/0, 3/7, a	IIU 3/0/11.					
	A physician's o	order, dated 3/9/11,					
	indicated, "ST.	AT [immediate]					
	BMP." A lab r	eport, dated 3/9/11,					
		were within normal					
	limits for potas	ssium at 4.8, with a					
	reference rang						
	A physician's order, dated 4/6/11,						
	indicated, "C	CBC [complete blood					
	count], CMP [complete metabolic					
	profile] in AM	[morning]." "Care					
	_	on the physician's					
	•	icated, "Problem:					
		th "Goal: Identify					
	possible revers	•					
	_	ncluded, but were					
		"Labs per order"					
		222 F 22 22 22 22 22 22 22 22 22 22 22 2					
	Documentation	n in the lab report					
		to indicate the results					
	of the labs ord	ered for 4/7/11.					
	During intervi	ew on 5/12/11 at 5:15					
	_	y's Nurse Consultant					
	•	ab ordered on 4/7/11					
	was not done.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155697	A. BUII		00	05/13/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	2. The clinical	l record for Resident					
	I was reviewed	d on 5/12/11 at 10:30					
	a.m. The reco	rd indicated the					
	resident was a	dmitted 3/22/11,					
	returned to the	hospital on 3/24/11,					
	was readmitted	d on 3/26/11, returned					
	to the hospital	on 3/27/11, was					
	readmitted on	4/7/11 and returned					
	to the hospital	on 4/9/11. The					
	resident was readmitted on 4/21/11.						
	The hospital D	Discharge Summary,					
		indicated diagnoses					
	included, but v	vere not limited to,					
	chronic abdom	ninal pain and					
	diarrhea with a	a questionable					
	gastrinoma. T	he "Hospital Course"					
	section indicat	ed, "with history of					
	chronic abdom	ninal pain and					
	diarrheaadm	itted for worsening of					
	her symptoms.	The patient was					
	re-seen by GI	[gastrointestinal] and					
	again there wa	s highly [sic] concern					
	-	. The patient's					
	octreotide [ant						
	medication] do	~					
	· ·	patient clinically					
	_	ove gradually and					
	cleared by GI	to be discharged					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155697	A. BUII		00	05/13/2	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	₹	1	SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG	home"	LSC IDENTIFYING INFORMATION)	+	TAG	BEITELENCTY		DATE
l	nome						
ı	Hospital disch	arge orders, signed					
	by the physicia	• •					
		were not limited to					
	ĺ	f the following					
	medications, "	Ocreotide 100 mcg					
	[micrograms]/	ml [milliliter]					
	injectable, 50 i	micrograms					
	subcutaneously, 3 times per day"						
	and Granisetro	on [antiemetic					
	medication] 1	mg [milligram]/ml					
	injectable, 2 m	ng, intravenous, every					
	morning." As	small question mark					
	was indicated:	next to the name of					
	the Granisetro	n.					
		n failed to indicate					
	the orders for t	the Ocreotide and					
		ere transcribed onto					
		hysician's orders list					
		. Documentation on					
		n Administration					
	Record failed						
		ere administered 4/21					
	through 4/26/1	1.					
	Nurgo's Notes	for 4/26/11 at 11:00					
	p.m. marcated	, "N/O [new order]					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155697	1	LDING	00	05/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	}	1	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		mcg/ml inj [inject]					<i>D.</i> 112
	50 mcg SubQ	[subcutaneously] TID					
		nily]. Ordered STAT					
	[immediately].						
		••••					
	Nurse's Notes	for 4/27/11 at 1:30					
	p.m., indicated	l, "Reviewed H&P					
	[History and P	hysical] [symbol for					
	- *	O for Granisetron."					
	-						
	The Medicatio	on Administration					
	Record (MAR) for 4/21/11 through					
	, ,	ted an undated entry					
		on 2 mg, i [one] PO					
		D [every day]. Give					
		arrives fr [from]					
		nurse's initials on the					
	_	d the first dose was					
	administered of						
		/11 ¬/∠//11.					
	During intervi	ew on 5/12/11 at 4:45					
	_	ty's Nurse Consultant					
	_	n Resident I was					
	readmitted on						
		not placed on the					
		sician's orders. She					
	indicated the n						
		a medication error					
	report had bee	II WIILLEII.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/13/2011		
	REHABILITATION A	ND SKILLED NURSING CENTER		517 N LI	DDRESS, CITY, STATE, ZIP CODE TTLE LEAGUE BLVD VILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			E	(X5) COMPLETION DATE
	p.m., the Nurs provided copy Error Acknow "Description of completed adm over & verify Ocreotide."	of a Medication ledgement indicating f error: When nission failed to carry Granistron and					
F0309 SS=D	must provide the resident will high blood po		F030)9	F 309 483.25 Provide care/services for highest well being. It is the practice of this provider to ensure that residents receive servicincluding labs to manage hyperkale What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	ces emia.	05/27/2011

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DHM211 Facility ID:

ty ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED)
		155697	B. WIN			05/13/2011	
		1	D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ITTLE LEAGUE BLVD		
CLARK I	REHABILITATION A	ND SKILLED NURSING CENTER	₹	1	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	+	TAG	The physician was notified of the I		DATE
monitoring and following				results of resident B on 4/5/11 for	10		
	physician's orders for potassium				medication clarification and again 4/6/11 with stat lab ordered.	on	
	supplements	for 1 of 1 resident			Lab was completed showing potas	sium	
	reviewed relat	ted to hypokalemia in			level within normal limits.	nto	
	a sample of 9	(Resident B)			How will you identify other resident having the potential to be affected to be affected to be affected.		
	a sumple of y.	(Resident B)			the same deficient practice and v	· .	
	l				corrective action will be taken: The facility recognizes that residen	nte	
	Findings inclu	ıde:			with laboratory orders have the po	I .	
					to be affected by this practice.		
	The clinical re	ecord for Resident B			A full facility audit was conducted All medical records identified were		
		on 5/11/11 at 12:45			reviewed to ensure physician		
					notification was completed.		
	p.m. The reco	ord indicated the			Licensed nurses were educated o 5/26/2011 on the policy for laborat	I .	
	resident was a	dmitted to the facility			orders including completion as ord	•	
	on 1/21/11.				with post tests completed.	laaa	
					What measures will be put into p or what systemic changes you w	I .	
	A1	1 1 - 4 - 1 1 /2 4 /11			make to ensure that the deficient		
	1 * *	order, dated 1/24/11,			practice does not recur Licensed nurses were educated	n	
	indicated, "D/	C [discontinue] Dx			5/26/2011 on the policy for labora		
	[diagnosis] De	ehydration Add Dx -			orders, including completion as		
	1	[low potassium],			ordered with post tests complete Treatment Administration Record	I	
	**	a [low sodium]"			were reviewed to ensure all lab		
	nyponatiemen	a from sourumj			orders present.	.	
					The DNS/designee will log and tr lab orders on Lab Tracking Log t		
	Physician's ad	mission orders,			include date of order, date lab	-	
	signed by the	physician on 1/23/11,			notified, date drawn, date results		
	1 5	were not limited to,			received and date physician noti How the corrective action(s) will	I .	
	1	· · · · · · · · · · · · · · · · · · ·			monitored to ensure the deficien	I .	
	Potassium 40	•			practice will not recur		
	[milliequivale	nts] PO [by mouth]			A CQI Audit of laboratory tool wi utilized weekly x 4 monthly x 2 th	I .	
	TID [three tin	nes daily]			quarterly thereafter to monitor fo	I	
	(supplement).				compliance.		
					DNS/designee will monitor audits ensure completion of audits.	, 10	
					Data collected will be submitted	io	
	Nurse's Notes	for 3/4/11 at 6:15			the CQI Committee for review an	t	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONS	00	(X3) DATE S COMPL 05/13/2 (ETED	
NAME OF P	PROVIDER OR SUPPLIER		l l		DRESS, CITY, STATE, ZIP CODE	03/13/20	011
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
IAG	p.m. indicated, MD of potassic level 6.9, order potassium, start NS [normal sates of 6:30 p.m. indicated for the intraver Physician order 9:30 p.m. indication of description of the infiltration, and "Repeat Berofile] q [even until stable. How Documentation section of the reindication of description of description of the reindicated she had no BMPs 13/5, 3/6, 3/7, and A physician's of the potassic properties of the period of the reindicated she had no BMPs 13/5, 3/6, 3/7, and A physician's of the potassic properties of the period	"Labs reported to um being @ critical rs received to hold rt IV [intravenous] line] bolus" ders, dated 3/4/11 at cated specific orders enous fluids. ers, dated 3/4/11 at cated intravenous be discontinued due oral fluids pushed, MP [basic metabolic ry] a.m. [morning] old potassium." In in the lab report record lacked aily BMPs. ew on 5/11/11 at 3:50 cal Records Director and contacted the lab, thad been done on and 3/8/11.	IAG		follow up as needed. An action pleasures identified by the CQI process. Compliance Date: 5/27/2011 ::identifying all laboratory orders.		DATE
	indicated, "ST	AT [immediate]					

155697		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING			ETED		
	PROVIDER OR SUPPLIER	II R ND SKILLED NURSING CENTER	₹	517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	BMP."						
	indicated resu normal limits with a reference The Medication Record (MAR indicated the repotassium sup through 3/31/2	n, dated 3/9/11, lts were within for potassium at 4.8, ce range of 3.6 to 5.0. on Administration new for March 2011 resident received no plements after 3/4/11 l1.					
	orders section indication the	of the record lacked physician order to ium supplements.					
	the resident re chloride, 40 m times daily on The MAR ind	April 2011 indicated ceived potassium aEq, by mouth three 4/1, 4/2, and 4/5/11. icated the resident nedication two times and 4/6/11.					
	indicated, "KO	order, dated 4/5/11, Cl [potassium nEq, i [one] PO [by					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	COMPL	ETED	
		155697	B. WINC			05/13/2	011
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
							(M.E.)
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
	mouth] QD [ev	very day]."					
	A physician's of indicated, "D/O 40 mEq TID [to Continue KCl ordered on 4/5 blood count], of metabolic profered included, "Prowith "Goal: It reversible factoricluded, but we "Labs per ordered included, but we we were a metabolic profession of the CBC and 4/7/11.	order, dated 4/6/11, C [discontinue] KCl three times daily], 10 mEq PO daily as /11, CBC [complete CMP [complete file] in AM fare Plan Update on sorder form oblem: Confusion" dentify possible ors." Interventions were not limited to, er" for 4/6/11 at 9:55 "Call to ARNP gistered Nurse or clarify KCl order os." In in the lab report to indicate the results d CMP ordered for					
	During intervi	ew on 5/12/11 at 5:15					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/13/2011		
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N LI	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	(X5) COMPLETION DATE
F0333 SS=D	indicated the lawas not done. This federal ta Complaints IN IN00090287. 3.1-37(a) The facility must efree of any signific Based on reconsinterview, the ensure medical administered aphysician upon hospital and delevated blood deficient pract significant medication administered significant medication significant medication administered significant medication sign	nsure that residents are ant medication errors. rd review and facility failed to tions were as prescribed by the n discharge from the aring an episode of a potassium. The ice resulted in a dication error for 2 of iewed related to ministration in a Resident I and	F0.	333	F 333 RESIDENTS FREE O SIGNIFICANT MED ERROR It is the practice of this facility administer medications as ordered. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The physician for resident I won to include on 4/26/11 and new orders were received. The admitted nurse had receeducation regarding transcription of admission orders on 4/27/11. The physician was notified on lab results of resident B on 4 for medication clarification are again on 4/6/11 with stat lab ordered. Lab was completed showing potassium level within normal limits. How will you identify other	S y to sived bition 2011. If the /5/11 and	05/27/2011

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2011	
	PROVIDER OR SUPPLIER	I ND SKILLED NURSING CENTE		STREET A	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129	ı
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR I was reviewed a.m. The reco	tatement of deficiencies cy must be perceded by full lsc identifying information) d on 5/12/11 at 10:30 rd indicated the dmitted 3/22/11,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) residents having the poter to be affected by the same deficient practice and wha corrective action will be ta	DATE Itial t
	returned to the was readmitted to the hospital readmitted on to the hospital	hospital on 3/24/11, d on 3/26/11, returned on 3/27/11, was 4/7/11 and returned on 4/9/11. The eadmitted on 4/21/11.			The facility recognizes that residents have the potential affected by this practice. Medication Administration Records were reviewed for appropriate documentation. All admissions/readmissions last 30 days were audited to ensure transcription of verificing discharging orders.	all to be
	dated 4/21/11, included, but we chronic abdome diarrhea with a gastrinoma. To section indicate chronic abdome diarrheaadme her symptoms re-seen by GI again there was	a questionable he "Hospital Course" ed, "with history of			What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur The DNS/designee will audinew orders and ensure transcribed onto medication administration record appropriately, Monday thru excluding holidays. All new admissions/re-admi will be audited on first busin day following admission to etranscription accurate as compared to verified dischalorders. All re-writes will be verified is	Friday ssions ess ensure rge
FORM CMS 2	octreotide [ant medication] do adjustedThe started to impr	idiarrheal osing was e patient clinically rove gradually and to be discharged	DHM211	Facility I	accurate by two licensed nuprior to beginning of month. Licensed nurses received education on 5/26/11 regard order transcription, admissis process and re-write proceswith post tests completed. How the corrective action(ding on dures s)

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2011	
		ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE COMPLETION DATE
	by the physicial included, but we continuation of medications, "[micrograms]/ injectable, 50 subcutaneously and Granisetro medication] 1 injectable, 2 mmorning." As was indicated the Granisetro. Documentation the orders for Granisetron with facility's plat readmission the Medication Record failed medication was through 4/26/11 Nurse's Notes p.m. indicated	were not limited to f the following Ocreotide 100 mcg ml [milliliter] micrograms y, 3 times per day" on [antiemetic mg [milligram]/ml ng, intravenous, every small question mark next to the name of n. In failed to indicate the Ocreotide and ere transcribed onto hysician's orders list a. Documentation on in Administration to indicate the its administered 4/21		will be monitored to ensure deficient practice will not The DNS/designee will complete CQI audit tool of MAR's, weekly x 4 monthly then quarterly thereafter to monitor for compliance to ensure new orders have be transcribed correctly. The DNS/designee will conduct admission audit first business after admission for accuracy of verified orders. The IDT will complete a review admission records 3 days post admission. The Data collected will be submeted to the CQI Committee for review follow up as needed. An action will be developed as needed for issues identified by the CQI products of Compliance: 05/27/2011::	recur y x 2 co een post- day of nitted y and plan coess.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIER	I ND SKILLED NURSING CENTER	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		[subcutaneously] TID ily]. Ordered STAT "					
	Record (MAR) 4/30/11 indicate for "Granisetro [by mouth] QI 1st dose when pharmacy." A	on Administration of or 4/21/11 through ted an undated entry on 2 mg, i [one] PO of [every day]. Give arrives fr [from] nurse's initials on the d the first dose was on 4/27/11.					
	p.m., the facili indicated when readmitted on Ocreotide was re-write of phy indicated the n	not placed on the vsician's orders. She curse had been medication error					
	p.m., the Nurse provided copy	of a Medication ledgement indicating					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155697	B. WIN	G		05/13/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION DATE
1710		nission failed to carry	+	mo	•		DATE
	•	•					
	_	Granisetron and					
	Ocreotide."						
		l record for Resident					
		ed on 5/11/11 at 12:45					
	p.m. The reco	rd indicated the					
	resident was a	dmitted to the facility					
	on 1/21/11.						
	A physician's o	order, dated 1/24/11,					
	1 1	C [discontinue] Dx					
	· ·	ehydration Add Dx -					
		low potassium],					
		-					
	nyponatremeta	a [low sodium]"					
	D1						
	l	mission orders,					
	1	physician on 1/23/11,					
	included, but v	were not limited to,					
	Potassium 40 i	mEq					
	[milliequivale	nts] PO [by mouth]					
	TID [three tim	es daily]					
	(supplement).'						
	Nurse's Notes	for 3/4/11 at 6:15					
		, "Labs reported to					
	· •	um being @ critical					
	_						
	l '	rs received to hold					
	potassium, stai	rt IV [intravenous]					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE S COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIER	I ND SKILLED NURSING CENTER	STR 517	7 N LI	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	NS [normal sa	line] bolus"					
	orders section indication the resume potass:	of the physician's of the record lacked physician order to ium supplements.					
	Record (MAR indicated the r) for March 2011 esident received no plements after 3/4/11					
	the resident re- chloride, 40 m times daily on The MAR indi	April 2011 indicated ceived potassium Eq, by mouth three 4/1, 4/2, and 4/5/11. Icated the resident redication two times and 4/6/11.					
	indicated, "KC	Eq, i [one] PO [by					
	a.m. indicated	for 4/6/11 at 9:55 , "Call to ARNP gistered Nurse					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THETETAL	or courternor	155697	A. BUILDING B. WING		05/13/2011
				ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	CLARK	SVILLE, IN47129	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	Practitioner] to	clarify KCl			
	order"	J			
	A physician's o	order, dated 4/6/11,			
		C [discontinue] KCl			
		three times daily],			
		10 mEq PO daily as			
	ordered on 4/5	-			
	This federal ta	g relates to			
		100090287 and			
	IN00090093.				
	3.1-25(b)(9)				
	3.1-48(c)(2)				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155697	B. WING		05/13/2011
NAME OF P	ROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	•
				LITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	CLAR	KSVILLE, IN47129	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		establish and maintain an	IAG	DEFICIENCE,	DATE
F0441 SS=F	*				
00 1	a safe, sanitary ar	nd comfortable environment			
	and to help prevent the development and				
	transmission of dis	sease and infection.			
	(a) Infection Control Program The facility must establish an Infection Control				
	Program under wh				
		ontrols, and prevents			
	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and				
		cord of incidents and related to infections.			
	corrective actions	related to injections.			
	(b) Preventing Spi	read of Infection			
	· ·	ction Control Program			
		resident needs isolation to			
	must isolate the re	d of infection, the facility			
		st prohibit employees with a			
	communicable dis	ease or infected skin			
		t contact with residents or			
	their food, if direct disease.	contact will transmit the			
		st require staff to wash their			
	• •	direct resident contact for			
		ng is indicated by accepted			
	professional pract	ice.			
	(c) Linens				
	Personnel must ha	andle, store, process and			
	•	as to prevent the spread of			
	infection.		F0441	This provider respectfully	05/27/2011
	Based on observation, record		FU441	requests additional evidentia	
	•	terview, the facility		information be entered into	the
	failed to identi	ify and investigate for		2567L and a lowering of sco	
	a possible scal	oies outbreak when a		and severity/ denial for resid C, D, F, and G. The current	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		(X2) M ¹ A. BUII B. WIN	LDING	00	(X3) DATE: COMPL 05/13/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		1	ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	resident was depossible scabic scabicidal media had ongoing see scabies. The fragrent assess resident rashes and itch identify expossible scabic treatment of resident revitated for the "possible scabic of 8 residents sample of 9 had which were not possible scabic facility's polic F, and G). The had the potent residents at the Findings included.	iagnosed with es and treated with a dication. The resident igns and symptoms of facility failed to ts and staff related to ning and failed to ure contacts for esidents and staff resident, in th its infection for Scabies Control. practice affected 1 of ewed who was diagnosis of ies." (Resident D) 5 reviewed in the nd rashes and itching out identified as es as indicated in the y. (Residents C, D, E, e deficient practice ial to affect all e facility.		IAG	2567L information omits significant facility information therefore misrepresents the and assessment administered the provider. Resident D had multiple consultation visits from various physicians including dermatologist for treatment of complaint of itching and rash since 11-30-2010. Per surveyor comment on passible scabies outbreak were sident was diagnosed with possible scabies and treated a scabicidal mediation." This implies that the facility had not assessed the resident that there was a reside with a positive diagnosis of scabies. Resident D was be treated for questionable all versus fungal rash since 11-30-2010 and has not even had a positive diagnosis of scabies. The facility content that the resident did not ha positive diagnosis of scabies. The facility content that the resident did not ha positive diagnosis of scabiand was being treated for rand itching as identified by facility. Most recent scrapin test results shows no scab therefore, no possible outb could occur. It is the policy of this facility eliminate and treat irritated skin areas, specifically a skin areas, spe	a and care ed by us of age hen a with feing ergy r ds ve a es ash age ies; reak y to kin	DATE
	Care On 3/11/1	1 ut 1.25 p.m., C1415			irritation caused by the itch	1	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155697	B. WIN			05/13/2011	
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX TAG	· `	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	PLETION ATE
IAG		e outside Resident	1	IAG	mite, Sarcoptes Scabiei, an		AIE
	D's door and donned gown, mask				prevent the spread of infect	ion.	
		-			The policy was followed as		
	and gloves in preparation for				evidenced based by which concern was brought to the	I	
	transferring Resident D from wheel				attention to the ED of a staf		
	chair to bed to provide personal				member that admitted to		
	care. A sign next at the door				having scabies. Once the		
	_	op and see the nurse			concern was identified, the		
		*			immediately responded price	or to	
	before entering. During interview				the time of survey, which negates the surveyor comn	nent	
	1	NA #4 indicated she			that the facility failed to ide		
		hy the protective			and investigate for a possib	- 1	
	equipment wa	s used, but the nurse			scabies outbreak.		
	would know.	CNA #4 indicated the			The facility immediately		
	family did not	use the protective			implemented a plan of action and followed the policy and	I	
	· -	en visiting the			procedure of Scabies Conti	II	
	1 * *	•			All residents skin assessm		
		ring care, Resident D			were completed. All staff w		
		to have a scaly, red			inserviced and inspected for	r	
	raised rash on	the chest and			any areas of concern. Any areas of concern identified	on	
	abdomen area	. The inner thighs			residents were further		
	were observed	d to have discreet red			assessed. Any staff member	r	
	dots the size of	of large pin heads.			who had areas of concern v	/ere	
		vas observed to			also sent for further		
					assessment. The facility correctly did		
		gging motion at the			identify resident G to have	<u> </u>	
		omen during care.			rash and itching and took		
	CNA #2 indicated the machine on				appropriate measures to tre	II	
	the end of the bed was for Resident				Appropriate interventions v	I	
	D's wound vac for the wound on his back, but she thought the wound vac was discontinued at the				put in place to help residen with rash and skin irritation		
					Facility needs to clarify		
					diagnosis of scables for		
					resident G, in which there v	ras	
	resident's med	lical appointment			no positive diagnosis of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			05/13/20	011
					ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIER	C		517 N L	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU				IAG	scabies. Order obtained for	· lah	DATE
	earlier in the day.				scraping, and waiting on	iab	
					results. It was explained to	ED	
	During observation on 5/11/11 at				that the Medical Director's		
	3:15 p.m., Resident D was observed				nurse practioner, assessed		
	seated in his high back wheel chair				resident G and based on		
	in the hallway at the nurse's station.				clinical observations did sh signs of scabies. To preven	_	
	1				the spread of infection due		
		vas wearing a short			possible exposure to scabi		
	sleeved shirt a	and geri-sleeves on			facility implemented cleaning	ng	
	both arms. Th	ne resident's head was			and treatment plan.		
	drooping forw	ard. The fingers of			The facility contends that resident D's clinical conditi	on	
		two hands were			did not have the potential to		
		ithing in a back and			affect other residents and		
					respectfully requests a		
		The resident used his			decrease in scope and seve	- 1	
	left hand to sc	ratch at the right			of the citation. The facility of in fact investigate, control a		
	upper arm and	I forearm and his right			prevent widespread infection		
	hand to scratch	h at the left upper arm			when a true concern was		
	and forearm.	The resident reached			identified. No residents in t	he	
		t with his left hand			facility had or have scables	;	
	and scratched				during January thru the present date. However, in		
					response to the alleged		
	shoulder vigor	rously.			deficient practice the follow	/ing	
					corrective action has been		
	During observ	ration on 5/11/11 at			implemented.		
	3:35 p.m., Res	sident D was seated in			For Prevention of possible exposure from staff member	_	
	_	wheel chair at the			immediate action did take	;ı,	
	_	The resident was			place:		
					C.N.A was suspended until		
	observed with his right hand beneath his shirt scratching with a				further investigation could		
					completed. It is the practice	of	
	digging motio	n on the chest and			this facility to prohibit employees with a		
	down the arm.	The left hand was			communicable disease or		

AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUIL	DING	NSTRUCTION 00	(X3) DATE SUF COMPLETI 05/13/201	ED
		155697	B. WING		DDDDGG GWW GWATE ZID GODE	03/13/201	'
NAME OF PROVI	DER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NURSING CENTER	_		SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E C	OMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·		IAG	infected skin lesions from		DATE
I		e right elbow			direct contact with resident	s.	
scr	ratching and	scratching.			Thoroughly inspect all		
					individuals including staff a	nd	
Du	iring observa	ation on 5/11/11 at			residents who have had		
4:1	15 p.m., Res	ident D was again			possible contact All individuals with suspicion	on	
		d in his high back			of possible exposure were		
		the hallway at the			treated at the same time.		
		The resident's			(Including all residents and		
					staff, and offered to all visit as well)	ors	
		re down around his			A Schedule for the following	a	
	· ·	resident was			was established:		
scr	ratching vigo	prously at his hands.			who would be treated and w	/ho	
					will do the treating. Specific treatment instruction	nne	
Th	e clinical re	cord for Resident D			When and Where treatment		
wa	s reviewed	on 5/11/11 at 11:40			be done.		
l a.n	n. The reco	rd indicated the			A cleaning schedule for the		
		eadmitted on 3/10/11			entire facility including resi- rooms, offices, therapy gyn		
					dining rooms, shower room		
I	•	ation on 3/6/11 for			and all other areas was		
tre	atment to a	ooil on the back.			developed and completed.		
					Linens and laundry were washed and bagged		
A	visit note fro	om a dermatologist's			appropriately.		
apj	pointment, d	ated 1/26/11,			Families and those at risk fo	or	
ind	dicated, "Exc	coriative dermatitis			possible exposure for scab	ies	
dif	fuse esp [esi	pecially] trunk. On			were notified. Staff has been educated on		
I		0 days if not okay."			Infection Control policy and		
					procedures including Scabi		
١,.	nhvaioian'a c	order dated 1/26/11			Control.		
1 -		order, dated 1/26/11,			C.N.A was later terminated to unsafe practices that ma		
I	dicated, "Bet				cause injury or illness aeb i	·	
I -	_	anti-inflammatory			following proper infection		
me	edication] 0.0	05% cream. Apply			control policy and procedur	es.	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		COMPL	
		155697	B. WIN	NG			05/13/2	U11
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE			
			ren.	1	ITTLE LEAGUE B	LVD		
		ND SKILLED NURSING CENT	IER	CLARK	SVILLE, IN47129			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED DEFICIE	TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	ENC I)		DATE
		sh on neck, torso,						
	bilateral arms	& back BID [twice						
	daily]. D/C [d	liscontinue] Mycolog						
	[antifungal me	edication] ointment."						
		_						
	Nurse's Notes indicated the							
	_	ted to skin issues						
	after 1/26/11:							
	2/1/11 at 3:45	p.m., "Rash						
		s scratching today						
	continues, ress	sociateming today						
	2/2/11 -4 2.00	"NO [
		p.m., "N.O. [new						
	order] per [nar	me of attending						
	physician], app	ply warm compresses						
	to L [left] ear]	TID [three times						
		area to L ear [symbol						
	2 3,	normal saline] apt dry						
	apply Bactroba	-						
	ointment] QD	[every day] & PRN						
	[as needed]."							
	2/8/11 at 2:00	p.m., "N.O. [new						
		ne of attending						
		ply warm compresses						
	to boil on L ax	alla Q [every]						
	shift"							
	A visit note from	om an appointment						
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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĭ .	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	
		155697	B. WIN			05/13/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	•	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	1	ITTLE LEAGUE BLVD SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		y/asthma specialist,	-	IAG	BETTELLICIT		DATE
		ndicated, "Chief					
	Complaint: Rash on back and all						
	_	etting boils. History					
	1 0	ess: [some words					
		ted on belly & waist					
		hy and itchy, no abx					
		o [symbol for change]					
	in meds [mediations] saw [name of						
	dermatologist] took Prednisone						
	[anti-inflammatory medication] X 1						
	week then aga	in + has MRSA					
	[methicillin re	sistant					
	staphylococcu	s aureus] - Bactroban					
	cream." The F	Review of Symptoms					
		note indicated,					
		Skin rash, severe					
	_	"Examination Detail"					
		note indicated for					
		ated areas - neck,					
	•	The "Diagnosis"					
		record indicated,					
		le] scabies. MRSA."					
		ated the resident in three weeks for					
		in three weeks for					
	follow-up.						
	A physician's o	order was received					
		ine [antibiotic] 100					
				!			

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Event ID:

DHM211

Facility ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN	G		05/13/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG			1	IAG			DATE
	mg, take i [one] PO [by mouth] BID [twice daily] X 10 days. Elimite						
		•					
	-	edication] Cream.					
		y all over body leave					
		nen bath/shower Q					
	day. D/C Beta	methasone					
	Dipropionate (0.05 Cream."					
	The Treatment	t Administration					
	Record indicat	ted the Elimite cream					
	was applied 2/	9/11 on the night					
	* *	esident showered the					
	next day.	obligation world the					
	next day.						
	On 2/11/11 at	6:30 p.m., Nurse's					
		d the resident's order					
		edication for itching)					
	`	from 25 mg three					
	•	50 mg three times					
	daily, the Dox	•					
	· ·	and an order was					
	received for "I						
	=	atory] 20 mg, take ii					
	[two] PO BID	X 1 day then					
	Prednisone 20 mg BID PO X 7						
	days."						
	The next Nurs	e's Note was dated					
		icated, "Remains					
	S/1/11 and ma						

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Event ID:

DHM211 Facility ID:

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If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN			05/13/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	1	CLARK	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCE		DATE
	1 ~	se's Notes for 3/3					
	through 3/6/11						
	1	ienced a change in					
		luding development					
	of a draining b	ooil on the back and					
	was transferre	d to the hospital on					
	3/6/11.	_					
	The hospital H	History and Physician					
	1 *	He was transferred to					
	· ·	y Room secondary to					
		•					
		d rash and a large					
	cellulitis/absc						
	backThe da	ughter states that the					
	rash has been	present since					
	November and	d he has been treated					
	with [sic] scat	pies in the past." The					
		, "I will consult					
		regarding the patient's					
	1	nsure as to what it					
		spital Dermatology					
	consult indica	ted, "Doubt					
	scabies."						
	On 5/11/11 at 2:50 p.m., the						
	Administrator provided a copy of						
	the facility's Scabies Control						
	1	July 2008. The policy					
	· -	OLICY: It is the					
	maicaica, 1 C						

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Event ID:

DHM211 Facility ID:

000059

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 05/13/2011	
	1000097	B. WI		DDRESS, CITY, STATE,		13/2011	
NAME OF I	PROVIDER OR SUPPLIER			ITTLE LEAGUE BL			
CLARK F	REHABILITATION AND SKILLED NURSING C	ENTER		SVILLE, IN47129			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIC		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE	
	policy of this facility to eliminate	,	-				
	and treat irritated skin areas,						
	specifically a skin irritation caused						
	by the itch mite, Sarcoptes scabiei,						
	and to prevent the spread of						
	infection. STANDARD: The						
	following are common signs,						
	symptoms, transmission route and						
	diagnosis: - Intense itching and						
	eruptions of burrows (small						
	discolored lines) and small red						
	elevations of the skin, which may						
	have fluid in them The hands,						
	fingers, wrist, underarms, genitalia						
	and inner aspect of the thigh are the						
	most common areas infected						
	Transmitted by physical contact.						
	PROCEDURE: - Thoroughly						
	inspect all individuals (residents						
	and staff) who have had 'hands on'						
	contact with the resident who has						
	been diagnosed All individuals						
	affected must be treated at the same						
	time Notify the Director of						
	Nursing, Housekeeping, Laundry,						
	and Dietary Departments and in the	,					
	Infection Control Practitioner						
	Determine a schedule that includes						
	the following: a. Who will be						
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155697 B. WING 05/1	3/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD	
CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN47129	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
treated and who will do the treating.	
b. Specific treatment instructions.	
c. Where treatment will be done. d.	
When treatment will be done. e.	
When will the person be considered	
non-infected Write a second	
schedule for the following: f.	
Persons needing a second treatment	
one week later, or as prescribed by	
the attending physician. g. Persons	
with crusted or infected lesions	
needing routine monitoring"	
During interview on 5/11/11 at 2:50	
p.m., the Administrator, Director of	
Nursing (DON), and Nurse	
Consultant indicated they had a	
concern related to scabies in the	
facility. The Administrator	
indicated she worked Sunday,	
5/7/11, and received report from a	
CNA that another CNA was not	
following standard precautions and	
had indicated she had been	
diagnosed with scabies. The	
Administrator indicated the CNA	
with scabies had been suspended	
and a plan was being implemented	
to treat all residents and staff for	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	COMPL	ETED
		155697	B. WING			05/13/2	011
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	scabies and im	plement a thorough					
	cleaning of the entire building. The						
	Administrator	indicated Resident G					
	had been diagr	nosed with scabies					
	today, based or	n his clinical					
	assessment. T	he DON indicated					
		be logged into the					
	infection contr	rol records.					
	During interview on 5/12/11 at 3:25						
	p.m., the Nurse Consultant						
	• 1	dent D's attending					
		visited earlier in the					
		ed the resident should					
	_	ital to find out what					
	-	em is and solve it for					
	the resident.						
	During intervio	ew on 5/13/11 at 3:40					
	p.m., the DON	indicated Resident					
		the outpatient lab at					
	_	r a skin scraping to					
		e had scabies. She					
		ospital lab had to					
	•	men to another lab					
		of the test would no					
	be available fo	or 48 to 72 hours.					
	During intervi	ew on 5/13/11 at 3:50					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		A. BUIL	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN47129	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	the infection of the treatment If the scabicidal in the DON indicated to check the in At 3:55 p.m., the diagnosis/the been noted on 2. The clinicated E was reviewed a.m. Documentation orders indicated to the abdomer began 12/27/1 order was recently indicated to the abdomer began 12/27/1 order was recently indicated to times daily]." A physician's of indicated, "Lad apply topically topically topically indicated in the scale indicated, "Lad apply topically indicated in the scale in the scale indicated in the scale in the scale in the scale in th	I record for Resident d 5/11/11 at 10:45 n in physician's ed treatment for a rash n and bilateral arms 1 when a physician's					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	A physician's of indicated, "Be [by mouth] q [hours] PRN [a Plan Update or order form indicated, "Note indicated, "Note [name of phys Hydrocortison cream to abd a [every] shift at [related to] rass [discontinue] of cream." The Othe physician's indicated, "Profipatient] to match A physician's of indicated, "Profipatient] to match a circle at Nurse's Notes was transported.	order, dated 2/27/11, nadryl 25 mg P.O. every] 6 [symbol for s needed]." The Care in the physician's licated, "Problem: order, dated 3/17/11, O. rec'd [received] by lician]. Start e cream 1%. Apply and bilateral arms q and as needed r/t lih X 2 weeks. D/C current Hydrocort 1% Care Plan Update on s order form oblem: Rush, Pt lintain skin integrity." order, dated 3/24/11, rm [dermatologist] to by the word "Rash" round it.	T	'AG			DATE	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUIL	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED		
	PROVIDER OR SUPPLIER REHABILITATION AF		B. WING GS/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	return, a physical 4/5/11, indicate Cephalexin [ar Give 250 mg Fadaily] r/t rash. Trimcinolone of 0.1% cream 80 bilateral arms, R/T rash. 3. St Give 10 mg Poitching. D/C [Benadryl [aller medication] or - Pt [patient] to hypoallergenical Apply Lubride [symbol for with and lanolin free Nurse's Notes was transported appointment or return, a physical 4/19/11, indical Prednisone 10 tabs P.O. Q a.r. for with] bkft [cian's order, dated ed, "1. Start ntibiotic] 250 mg. PO QID [four times 2. Start [anti-inflammatory] param. Apply to back and chest TID art Atarax 10 mg. Po QID as needed R/T discontinue] current rgy/itching der." 4. Dove Soap pouse only dove soap, a laundry detergent. 5. From lotion to dry skin with fragrance free e." indicated the resident d to a medical n 4/19/11, and upon cian's order, dated ated, "Start mg R/T rash - Give 3 m. [morning] [symbol [breakfast]." The late of the order form		TAG	DEFICIENCY)		DATE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155697	A. BUI		00	05/13/2	
		100001	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	100/10/2	
NAME OF F	PROVIDER OR SUPPLIER			1	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	2	CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	integrity."	ESC IDENTIF TING INFORMATION)		IAG			DAIL
	integrity.						
	Nurse's Notes from 3/18/11 through						
	4/5/11 indicated Benadryl was						
	administered f	or complaints of					
	itching on the	following dates and					
		owing related to the					
	resident's rash	and itching: 3/21/11					
	at 10:48 p.m., 3/22/11 at 11:00 a.m., 3/23/11 at 10:00 a.m., 3/24/11 at						
	9:30 a.m.,3/26	/11 at 3:00 a.m.,					
		30 a.m., 3/27/11 at					
	· ·	29/11 at 7:00 p.m.,					
		30 p.m., 4/1/11 at					
	5:00 a.m., 4/1/	11 at 10:45 a.m.					
		C 4/2/11 + 11 00					
		for 4/2/11 at 11:00					
	_	, "Only notice res					
	itching before	lunch"					
	Nurse's Notes	for 4/4/11 at 4:00					
		, "C/O itching					
	[symbol for with] red bumps dry & flaky skin."						
	TIMILY SIXIII.						
	Nurse's Notes	indicated Atarax was					
		or itching as follows:					
		e indicated), 4/6/11 at					
	`	11 at 5:30 a.m.,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155697		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/13/2	ETED		
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	l .		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	4/9/11 at 10:1:	5 a.m., 4/13/11 at						
	3:00 a.m., 4/15/11 at 3:00 a.m.,							
		00 a.m., 4/27/11 at						
		/11 at 11:00 p.m., and						
	5/7/11 at 9:50	a.m.						
	Nurse's Notes also indicated the							
		lained of itching as						
	_	/11 at 6:45 p.m.,						
	4/14/11 at 2:00 a.m., 4/15/11 at							
		8/11 at 8:00 p.m.,						
	4/19/11 at 8:0	0 p.m., 4/23/11 at						
	8:30 p.m.							
		0 4/16/11 + 0.00						
	l	for 4/16/11 at 3:00						
		, "con't [continued]						
	- *	nbol for after] med						
	[mediation] &	IUIIUII						
	Nurse's Notes	for 4/17/11 at 4:15						
		, "itchy rash to trunk						
	& BUE [bilate	, ,						
	extremities].	11						
	Nurse's Notes	for 5/1/11 at 11:00						
	l ^	, "was itching						
	earlier in shift	"						
	The Weekly S	kin Assessment, dated						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	COMPL	
		155697	A. BUI B. WIN	ILDING		05/13/2	
			D. WIN		DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER	R		517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
		ted the resident had					
	· ·	tes indicated, "Note					
		arms & torso. Skin					
	warm to touch	and intact. Tx					
	[treatment] co	mplete q [every] shift.					
	= =] well. [symbol for					
	=	and symptoms] of					
	distress."	J 1 J					
	On 5/8/11 at 7:00 p.m., Nurse's						
	Notes indicated a physician's orders						
	were received to "culture boil on						
	back." On 5/9	0/11 at 1:30 p.m., the					
		ransferred to the					
	emergency roo	om for evaluation and					
	treatment of th						
	3. The clinica	l record for Resident					
	F was reviewe	ed on 5/11/11. at					
	11:25 a.m.						
	Nurse's Notes.	, dated 4/28/11 at					
	2:00 p.m., ind						
	-	[complained of]					
	= =	ching. MD notified.					
	N.O. [new ord						
	-	g medication] 10 mg					
	PO Q day X 1						
		<i>J</i>					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIEF		_	517 N L	DDRESS, CITY, STATE, ZIP CODE	•	
		ND SKILLED NURSING CENTER	`		SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Nurse's Notes	, dated 5/5/11 at 2:40					
	p.m., indicated, "Res. has red rash						
	to whole torso	o. MD notified. N.O.					
	Triamcinolone	e 0.1% to rash BID X					
	10 days"						
	The physician	's order for the					
	Triamcinolone						
	notation, "Please send large						
amount r/t [related to large amount							
	of rash."						
	The Weekly Skin Assessment, dated						
	1	ted, "rash on					
	abdomen."						
	During observ	vation of Resident F's					
	personal care	by CNA #4 and CNA					
	#6 on 11:50 a.	m., with two family					
	members pres	ent, the resident was					
	observed to ha	ave light red lines					
		st between the					
	breasts. The r	resident was observed					
	to scratch/dig at the upper arms and						
	chest and complaint of itching.						
		ew with the resident's					
	· ·	er at this time, the					
	1 *	er indicated the					
	resident had b	een treated with a					

AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155697 A BUILDING DO COMPLETED D5/13/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, INAT/12 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CLARKSVILLE, INAT/12 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION COMPLETION COMPLETION CROSS-REPERSISHED TO the APPROPRIATE CROSS-RE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129 CLARKSVILLE, IN47129 IO PROVIDERS RAN OF CORRECTION (CS) COMPLETION TAG Iotion for scabies the preceding day, and she wanted to be sure the treatment would be repeated in seven days. During confidential telephone interview on 5/11/11 with the resident's family member, the family member indicated the resident complained about two weeks ago of itching. The family member said it looked like the resident had scabies. The family member said it looked like the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. ВІЛІ	LDING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER (X4) ID PREFIX (LEACH DEFICIENCY MIST BE PERCEISED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Dition for scabies the preceding day, and she wanted to be sure the treatment would be repeated in seven days. During confidential telephone interview on 5/11/11 with the resident's family member, the family member indicated the resident complained about two weeks ago of itching. The family member said it looked like the resident had scabies. The family member said the doctor ordered Claritin and a lotion, but the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00			155697	1			05/13/2	011
CLARK REHABILITATION AND SKILLED NURSING CENTER (CACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Iotion for scabies the preceding day, and she wanted to be sure the treatment would be repeated in seven days. During confidential telephone interview on 5/11/11 with the resident complained about two weeks ago of itching. The family member said it looked like the resident had scabies. The family member said the doctor ordered Claritin and a lotion, but the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00	NAME OF F	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
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member indicated another family member said it looked like the resident had scabies. The family member said the doctor ordered Claritin and a lotion, but the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00		•						
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resident had scabies. The family member said the doctor ordered Claritin and a lotion, but the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00			·					
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Claritin and a lotion, but the resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00		resident had so	cabies. The family					
resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00		member said t	he doctor ordered					
resident continued to complain of itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00		Claritin and a	lotion, but the					
itching. 4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00								
4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00								
C was reviewed on 5/12/11 at 11:00								
C was reviewed on 5/12/11 at 11:00		4. The clinica	l record for Resident					
		a.III.						
A physician's order, dated 4/15/11,		A physician's	order, dated 4/15/11.					
included, but was not limited to,								
"Benadryl cream to rash bid." The								
		-						
Care Plan Update section of the		_						
order form indicated a Problem of								
"Rash UE [upper extremities, abd		"Rash UE [up	per extremities, abd					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155697	A. BUII	LDING	00	COMPL 05/13/2	
		155097	B. WIN		DDDDGG CITY CTATE TID CODE	03/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER	!	1	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ck." Documentation	+	IAG			DATE
	in Nurse's Notes and Weekly Skin Assessment Sheets failed to						
	indicate a description of the resident's rash.						
	resident s tasn.						
	The Medication Administration						
	Record for April 15 through 25,						
	2011 indicated the Benadryl cream was applied two times daily. The						
		withheld one time on					
	4/26/11 with th	<i>'</i>					
	_	hheld. rash subsided.					
	-	O." The Benadryl					
	was applied or	ne time on 4/28, 4/29					
	and 4/30/11.	The Medication					
	Administration	n Record for May					
	2011 indicated	I the medication was					
	administered to	wice daily on May 1					
	through 7, onc	e on May 8, twice on					
	5/9, and once of	on 5/10, 11, and					
	12/11.						
	Documentation	n on the Weekly Skin					
		ated 5/3/11, failed to					
	indicate the res						
	Nurse's Notes	for 5/7/11 at 5:00					
		l, "Tx [treatment]					
	P.III., IIIaicatec	-, In [Houmiont]					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAIN	OF CORRECTION	155697	1	LDING	00	05/13/2	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	1	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710	applied to rash	· · · · · · · · · · · · · · · · · · ·	1	1110			DITTE
	applied to rush						
	5. The clinical record for Resident						
	G was reviewe	ed on 5/12/11 at 3:15					
	p.m.						
	1						
	Nurse's Notes	for 2/15 through					
		indicate information					
	related to rashes and itching. A Weekly Skin Assessment, dated						
	5/11/11, indica	ated the resident had					
	ŕ	/Rash." The entry					
		on/Site" indicated,					
	•	eas." The site was					
	not indicated.						
ı							
	A Nurse Practi	tioner's note, dated					
	5/11/11 indica	ŕ					
		[patient] seen today					
	_	vord] rash to groin &					
	abdomen. Pt.	- •					
		e note included, but					
	_	d to, "Location: abd					
	[abdominal] rash linear; Severity: 3						
		as; Duration: >					
	[greater than]						
		tant." The Review of					
	_	ated, "Skin: Rash to					
		, omin. Rush to					

∥ 155697		1	2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING (05/13/2011)					
		100097	B. WING			05/13/2	UII	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
CLARK F	REHABILITATION AI	ND SKILLED NURSING CENTER						
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	П	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE	
	_	Exam indicated,						
]: Pruritis to abd;						
		ear & [illegible						
		oruritic rash constant						
		ith] dermatitis poss.						
		pies exposure."						
		dicated, "1) Contact						
		Pruritis 3) Anxiety."						
	The Treatment Plan indicated the							
		be treated with a						
		lication, all other						
		ould be continued,						
	and follow-up	as needed.						
	This federal ta	g relates to						
	Complaint IN	_						
	3.1-18(b)(1)(A	A)						
	3.1-18(b)(2)							
	3.1-18(b)(3)							